

CANADIAN JOINT REPLACEMENT REGISTRY

HIP REPLACEMENT DATA COLLECTION FORM

Femoral Component Replaced/ Resurfaced? <input type="checkbox"/> Yes → <input type="checkbox"/> No ↓	Surface Replacement? <input type="checkbox"/> Yes <input type="checkbox"/> No Cemented? <input type="checkbox"/> Yes <input type="checkbox"/> No If Cemented: Porosity Reduction: <input type="checkbox"/> Yes <input type="checkbox"/> No If Cementless, Check ALL that apply: <input type="checkbox"/> Porous In-growth <input type="checkbox"/> H. A. Coated <input type="checkbox"/> Grit Blasted Modular Stem? <input type="checkbox"/> Yes <input type="checkbox"/> No	Manufacturer See Legend Below Femoral Component <input style="width:100%; height:30px;" type="text"/>	Affix sticker(s) or catalogue and lot number beside the specific component. <u>Do not include stickers for screws.</u> Sticker for Femoral Component																														
Femoral Head Replaced? <input type="checkbox"/> Yes → <input type="checkbox"/> No ↓	Modular Head? <input type="checkbox"/> Yes <input type="checkbox"/> No Outside Diameter: _____ mm Material: <input type="checkbox"/> Cobalt Chrome <input type="checkbox"/> Ceramic Zirconia <input type="checkbox"/> Ceramic Alumina <input type="checkbox"/> Oxinium <input type="checkbox"/> Other <input type="checkbox"/> Stainless steel Hemiarthroplasty? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, <input type="checkbox"/> Monopolar <input type="checkbox"/> Bipolar	Manufacturer Femoral Head <input style="width:100%; height:50px;" type="text"/>	Sticker for Femoral Head																														
Acetabular Component Replaced? <input type="checkbox"/> Yes → <input type="checkbox"/> No → ↓	Cemented? <input type="checkbox"/> Yes <input type="checkbox"/> No If Cemented: Same cement used for femoral component? <input type="checkbox"/> Yes <input type="checkbox"/> No If Cementless, Check ALL that apply: <input type="checkbox"/> Porous In-growth <input type="checkbox"/> Screws? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> H.A. Coated <input type="checkbox"/> Screws? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Trabecular metal <input type="checkbox"/> Screws? <input type="checkbox"/> Yes <input type="checkbox"/> No Outside Diameter: _____ mm Tripolar Revision? <input type="checkbox"/> Yes <input type="checkbox"/> No Constrained Cup? <input type="checkbox"/> Yes <input type="checkbox"/> No	Manufacturer Acetabular Component <input style="width:100%; height:30px;" type="text"/>	Sticker for Acetabular Component																														
Acetabular Insert/Liner Replaced? <input type="checkbox"/> Yes → <input type="checkbox"/> No → ↓	Material: (Check ONE only) <input type="checkbox"/> Polyethylene standard <input type="checkbox"/> Ceramic Alumina <input type="checkbox"/> Polyethylene cross-linked <input type="checkbox"/> Metal <input type="checkbox"/> Other Modular? <input type="checkbox"/> Yes <input type="checkbox"/> No	Manufacturer Acetabular Liner <input style="width:100%; height:30px;" type="text"/>	Sticker for Acetabular Liner																														
Ring/Cage Used?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Manufacturer Ring/Cage <input style="width:100%; height:30px;" type="text"/>	Sticker for Acetabular Ring/Cage																														
Trabecular Metal Augment for Acetabulum used? <input type="checkbox"/> Yes <input type="checkbox"/> No																																	
Cement Details (Femoral Component) Cement Used? <input type="checkbox"/> Yes → <input type="checkbox"/> No ↓	For each item, Check ONE only: Cement Name: <input type="checkbox"/> Simplex <input type="checkbox"/> Zimmer <input type="checkbox"/> CMW <input type="checkbox"/> Versabond <input type="checkbox"/> Palacos <input type="checkbox"/> Osteobond <input type="checkbox"/> Cerafix <input type="checkbox"/> Other _____ Antibiotics added by manufacturer? <input type="checkbox"/> Yes <input type="checkbox"/> No Antibiotics added by surgeon? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, Antibiotic Name: <input type="checkbox"/> Tobramycin <input type="checkbox"/> Vancomycin <input type="checkbox"/> Gentamicin <input type="checkbox"/> Erythromycin <input type="checkbox"/> Other Mixing Method: <input type="checkbox"/> Vacuum-mixed <input type="checkbox"/> Centrifuge <input type="checkbox"/> Manually Mixed		Sticker for Cement Type																														
Bone Graft Used—Femur <input type="checkbox"/> Yes → <input type="checkbox"/> No ↓	Check ALL that apply: <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th colspan="3" style="text-align: center; border-bottom: 1px solid black;">Autograft</th> <th style="text-align: center; border-bottom: 1px solid black;">Allograft</th> <th style="text-align: center; border-bottom: 1px solid black;">Bone Graft Substitute</th> </tr> <tr> <th></th> <th style="text-align: center; border-bottom: 1px solid black;">Iliac crest</th> <th style="text-align: center; border-bottom: 1px solid black;">Femoral head</th> <th style="text-align: center; border-bottom: 1px solid black;">Other</th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>Structural</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Strut/Onlay</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Morselized</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>				Autograft			Allograft	Bone Graft Substitute		Iliac crest	Femoral head	Other			Structural	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strut/Onlay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Morselized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Autograft			Allograft	Bone Graft Substitute																												
	Iliac crest	Femoral head	Other																														
Structural	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												
Strut/Onlay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												
Morselized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												
Bone Graft Used—Acetabulum <input type="checkbox"/> Yes → <input type="checkbox"/> No ↓	Check ALL that apply: <table style="width:100%; border-collapse: collapse;"> <thead> <tr> <th></th> <th colspan="3" style="text-align: center; border-bottom: 1px solid black;">Autograft</th> <th style="text-align: center; border-bottom: 1px solid black;">Allograft</th> <th style="text-align: center; border-bottom: 1px solid black;">Bone Graft Substitute</th> </tr> <tr> <th></th> <th style="text-align: center; border-bottom: 1px solid black;">Iliac crest</th> <th style="text-align: center; border-bottom: 1px solid black;">Femoral head</th> <th style="text-align: center; border-bottom: 1px solid black;">Other</th> <th></th> <th></th> </tr> </thead> <tbody> <tr> <td>Structural</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Strut/Onlay</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> <tr> <td>Morselized</td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> <td style="text-align: center;"><input type="checkbox"/></td> </tr> </tbody> </table>				Autograft			Allograft	Bone Graft Substitute		Iliac crest	Femoral head	Other			Structural	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Strut/Onlay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Morselized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Autograft			Allograft	Bone Graft Substitute																												
	Iliac crest	Femoral head	Other																														
Structural	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												
Strut/Onlay	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												
Morselized	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>																												

Legend of Manufacturer Codes: 01 Biomet 03 J&J/DePuy 05 Zimmer 07 Smith & Nephew Richards 99 Other
 02 Ceraver 04 Sulzer/Centerpulse 06 Wright Medical 08 Stryker/Osteonic/Howmedica